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ORIGINAL ARTICLES.

Gonorrhœal Ophthalmia.

BY G. A. WALL, M.D., TOPEKA, KAN.

Oculist and Aurist, A. T. & S. F. Hospital Association and C. R. I. & P. R'y.

Read before the Central Medical Society, at Greenleaf, Kan., Sept. 6, 1894.

My excuse for asking your indulgence in listening to this paper is this: Gonorrhœal ophthalmia is one of the gravest forms of inflammation that attacks the eye. It is a disease in which the sight may be absolutely destroyed in a very short period when we encounter it in its most severe form. Again, I am constrained to say that under proper treatment, and when seen early, before any corneal complications arise, we should seldom, if ever, lose the sight in toto.

I have recently had an experience with a grave case which I believe fully demonstrates the correctness of my position. The main object in these cases, when seen early, is proper treatment, and I shall try to inform you as best I know how what that proper treatment is.

Before going further, it would perhaps be well to briefly outline the causes, symptoms, prophylaxis and diagnosis, because upon its early recognition depends, in a great measure, your success in its treatment. Do not turn a case away with the information that it is only a bad cold and thus place the patient in the deplorable position of a chance to become blind in one eye or both, because if you recognize it when first seen it will be almost *criminal negligence* to lose the sight of both eyes.

Gonorrhœal ophthalmia is practically the same as the ophthalmia neonatorum of infants in all its characteristics. In a few instances it seems to be of spontaneous origin, but these are very rare, and some source of contagion can, in a majority of cases, be traced. We may have it from an acute or a chronic gonorrhœa, by communication from a similarly diseased eye, or by direct contact through the fingers, towels, handkerchiefs, etc., the quantity of pus that will cause a very severe case of gonorrhœal ophthalmia being very small. I have seen very severe cases following a case of gleet, and again, milder cases following cases of acute gonorrhœa. The eye most generally affected in adults is, of course, the right eye, as it stands to reason that in dressing the parts so afflicted one usually uses the right hand and in this manner carries the discharge from the penis to the eye.

The efficient agent in the production of this disease is the gonococcus of Neisser. This has been demonstrated time and time again from the fact that inoculation from the pus of the gonorrhœal ophthalmia will cause a case of gonorrhœa. The period of incubation of this disease is about forty-eight hours. The symptoms can perhaps best be given in the following language from Noyes' text book on diseases of the eye:

"The symptoms are at the outset hyperæmia of the ocular conjunctiva, swelling of the lids, which speedily closes them, and a thin and ichorous discharge; there will be smarting and burning, which soon rises to pain both in and around the eye. Oedematous infiltration increases in the lids until they become hard, tense, and shine with a dusky red, and the upper overhangs the lower lid. A similar infiltration takes place beneath the ocular conjunctiva, lifting it from the globe, and making it mount over

the edge of the cornea. This condition is called chemosis. The secretion in a little time becomes more and more purulent, and soon seems wholly of this quality. The temperature of the parts is elevated, and the whole picture is that of an excessively severe inflammatory process. If the lids can be separated, the conjunctiva is not only deeply red, but it is often speckled with hemorrhages. It is also covered with pus, especially on the palpebral surface during the early period, there will also often be a layer of plastic exudation which will come off in rolls, or may adhere rather closely. When wiped away the surface beneath it bleeds. It is oftentimes impossible to separate the lids enough to view the eye properly, and an attempt causes so much pain that the patient involuntarily and strenuously resists it."

The appearance of a case of gonorrhœal ophthalmia, when once seen, can hardly ever be mistaken, great pain from the intense swelling on the side of the face, extending down on to the lips and chin, to the forehead, and involving the pre-auricular gland, which, in the cases I have seen, has always been more or less tender.

The culmination of the active symptoms generally subsides in from four to five days, but there still remains a reddening and thickening of the conjunctiva, which does not entirely disappear for from five to six weeks and perhaps even longer.

The great danger in this disease is to the cornea. The intense swelling about the cornea constricts the blood vessels, thereby interfering with its blood supply, and in this manner suppuration of the corneal tissue will take place.

Having seen a case of gonorrhœal ophthalmia *and recognized it*, the first important thing is to prevent inflammation from attacking the fellow eye. This may be done in one of two ways: After covering it with cotton it may be sealed with rubber adhesive plaster, but the great objection to this method is that it places the patient in a state of total darkness, because it entirely closes the well eye, and again, it is not a very comfortable dressing from the fact that the eye becomes heated under it, and after awhile becomes very disagreeable. The best method to my mind is that known as Buller's Shield. This consists, as I show you here, of a watch glass, fastened between two strips of rubber adhesive plaster in such a manner that we may seal the eye almost hermetically and still leave it free to perform its function of vision. In putting it on it is important that the adhesive plaster be thoroughly pressed down over the nose, and over the brow and cheek because the pus from the fellow eye may readily ooze under it unless it is carefully adjusted at these points. However, at the outer and lower corner we should leave a space in which the plaster is not fastened to the cheek for the purpose of ventilation. Unless we do this the eye also becomes heated, and will oftentimes look very red and feel very disagreeable.

A very important thing in this disease is the treatment, for, as I have stated in the early part of this paper, I believe that if seen early, and before the cornea is affected, we should not lose the vision except in the rarest instances. From the beginning, active measures should be adopted. The first thing to do is to place your patient in a recumbent position, and keep him in a dark room with good ventilation. In order to avoid as much as possible corneal complications wash the eye out regularly every fifteen minutes for the first three days with an antiseptic solution. I have used in all my cases, and prefer it, a solution of bichloride of mercury—1 to 5,000—and find that it answers the purposes very admirably. Of course, many other antiseptics could be used, such as boric acid solution, chlorinated water, etc. The great objection to boric acid is that its antiseptic qualities are very feeble, and this is not a disease in which we can use experimental remedies, but it is one in which it is necessary to use some of the old stand-bys, such as bichloride of mercury solution, which, as we all know, does its work, and does it well, when necessity requires.

The manner of washing the eye is one in which but little instruction is given in the

text books, so far as I have been able to learn. They tell us to wash the eye, but their instructions are very meagre. The use of syringes they deprecate for various reasons, among them that it is dangerous to the operator to use this instrument from the fact the sudden gush of water into the eye may throw some of the pus into the eyes of the attendants, thereby causing gonorrhœal opthalmia in them. Another is that the cornea may be injured by the force of the stream. These objections I believe to be well founded, and I therefore never use the piston syringe in the treatment of my cases. I use the bichloride solution in a manner which I believe to be original with myself, as I have never seen it stated elsewhere. I take a fountain syringe, fastening the reservoir just high enough on the side of the bed, or having an attendant to hold it, in order that the force of the water may be very slight, but still strong enough to wash away all the pus that may be beneath the lids. This I have found to be the best method to get rid of the accumulation of pus under the upper lid. This is a very important matter, for it is from this pus that the eye should be entirely freed, if possible.

As to opening the lids, the best manner is by using the elevator, of course, with great care, because the lids are very tender and bleed upon the slightest touch during the height of the inflammation. During the time that the discharge is thin and ichorous and the chemosis is very great nothing at all should be done in the way of treatment except the washing of the eye with the antiseptic solution, as I have stated, every fifteen minutes continually night and day. Of course, it is well to say here that your patient rapidly becomes exhausted from loss of sleep and intense pain, and it is a wise idea to give him small doses of morphia by hypodermic injection to at least appease the pain. Of course, it is impossible to obtain rest on account of the necessity for frequent washing. A patient suffering from this disease undergoes a severe ordeal, and at the end of a week's siege will perceptibly show it by loss of physical strength.

The fidelity and thoroughness with which these washings are done will have the greatest influence in your fight for the preservation of the eye. Should the cornea become invaded as it may in the course of the disease, the first thing you will notice by carefully glancing at is a gray spot or infiltration somewhere on the surface, perhaps in the center, but more frequently peripheral, and then you have call for another remedy, and that is sulphate of atropia, two grains to the ounce of distilled water. A drop should be used every three or four hours until the pupil is dilated, and then once a day will be sufficient. I may say here that this is used in case the ulcer is central; if it be peripheral we have another remedy which becomes of use, and that is sulphate of eserine, one-fourth grain to the ounce of water. This should be dropped in the eye once a day or perhaps twice a day until the pupil becomes contracted. The object in the use of these different medicines is this: If the ulcer is central and perforates, the iris will prolapse through the perforation, and we use the atropia to dilate the pupil and to keep the edges of the iris away from the perforation. On the other hand, if the ulcer be peripheral and perforation of the cornea ensue, of course, the atropia would be contra-indicated for the reason that the pupil would be dilated, and after perforation at the peripheral part of the cornea it would prolapse through the opening. In order to avoid this we use the eserine, which contracts the pupil, and consequently keeps the edges of the iris away from the perforation.

After the cessation of the ichorous discharge, and it becomes creamy and thick, then we have use for that great antiseptic, nitrate of silver. The manner of using this is perhaps not known to all of you, or perhaps, at least, the proper manner of using it, so I will explain how I use it. The first thing is to have the proper strength solution. I generally use a two per cent. solution; that is, ten grains to the ounce of distilled water. I am aware of the fact that many good and eminent practitioners use stronger solutions, but I believe the experience and observation of men throughout

the country, as well as my own, have proven that the solution just mentioned will answer the purposes of all of them. We can vary the effect of our application by lengthening the intervals between applications, and the time in which we wash the surplus away with pure water. I say pure water, because many recommend the use of salt and water. This, to my mind, is superfluous for the reason that we neutralize but little of the silver itself. All we do is to wash away the surplus of solution that remains on the conjunctiva. Of course, you all know that the solution that comes in direct contact with this membrane forms an albuminate of silver, which can be recognized as a whitish, thin membrane covering the inside of the lids after application. It is always well to take a piece of cotton and wrap it around a probe and wipe away this membrane before leaving the patient after the application of the silver.

The manner of applying the silver is another important matter in the treatment of our cases, because unless it is properly applied, it will have no effect whatever. I usually apply it in this manner: I evert the lid or lids, and then take my mop, consisting of absorbent cotton wrapped around a probe, and apply the solutiou thoroughly to the lids with this. We very often find in the dispensary practice the use of camel's hair brushes, and oftentimes wonder why the disease is not communicated from one patient to another by the use of the same brush. The reason for this is that the silver, being an antiseptic, destroys the microbe, and in this manner prevents contagion. Do not use a brush, because there is a possibility of killing the microbes, for it is at any time a very uncleanly manner of applying the solution. By using the absorbent cotton and probe we can always throw away that which has been used and have a fresh piece for each application of the solution.

The application of nitrate of silver should not be made oftener than once in twenty-four hours, and as the disease abates, once every two days will suffice. Never drop your solution of nitrate of silver into the eye with a dropper, because by doing so, you endanger the corneal tissue and may perhaps hasten ulceration which otherwise might not have taken place.

Free Scholarships in the Kansas Medical College.

Two free scholarships have been endowed in the Kansas Medical College. One known as the J. C. McClintock scholarship, and the other as the S. E. Sheldon scholarship. The privileges of these scholarships are open to students under the following conditions, which are prescribed in both:

"This scholarship will be open to any first course white student who furnishes a certificate from his or her preceptor stating that the student is unable to pay the college fees, and provided that the student is otherwise eligible for admission to the college.

"In case there are two or more applicants for the scholarship, it shall be allotted to the student passing the best examinations on the first Monday following the opening of the Kansas Medical College in 1894 before a special committee consisting of the secretary of the college and two members of the Faculty to be appointed by the Dean, said examinations to be in Latin, physics, and English composition."

THE Marion Sims Medical College of St. Louis reports an exceedingly large enrollment for this year. The officers of the college predict a class of 350 students.

THE faculty of the Kansas Medical College will give a reception at the College building on Tuesday evening, September 18th.

DR. S. J. HAMPSHIRE has located at Overbrook, Kas.

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Topeka, Kansas, Saturday, Sept. 15, 1894.

Some Improvements in Public Hygiene.

A few months ago we had occasion to criticize the Topeka School Board for their negligence in regard to sanitary provisions at the public school buildings. It is a pleasure now to commend the effort they have made to correct the existing evils. At the Clay school, the one particularly referred to, the closets have all been connected with the sewer. New vaults have been made, and every possible facility added for keeping the closets in good condition and thereby protecting our children from the ravages of contagious disease, which has formerly characterized each session of the school. We think there is no doubt that the foul vaults and leaky boxes, undoubtedly infected with disease germs, were a prolific source of diphtheria and scarlet fever. Every session of Clay school for the past six years has been marked by a series of cases of these diseases among the pupils in attendance. Many deaths have occurred which may be ascribed to the negligence of those to whom the proper management of our public schools has been delegated. The city health officer deserves credit for bringing about the present change. It was only after he had notified the Board that he would prohibit the opening of the school that they consented to make the necessary improvements.

Kaw Valley Medical Act Association.

The organization purposes, etc., of this society are very clearly set forth in the minutes of the meeting as given below. We most heartily commend the spirit of the organization and tender our services toward securing the best possible results. Every physician to whom medical legislation is an object should be on hand at the next meeting:

"On Thursday afternoon, September 6, 1894, a meeting of physicians was held at I. O. O. F. hall, Wamego. The object of the meeting was for the purpose of organizing a society to unite the physicians throughout the State in an effort to influence legislature to protect the people against public frauds, and the ravages of traveling quacks, and to encourage, the honest, legitimate practice of medicine.

"Those in attendance were as follows: A. H. Brill, of Louisville; A. E. Gundry, of St. Marys. G. C. Beals, of Alma; J. W. Wilhoit, of St. George; M. W. Armstrong, of Wabaunsee; J. S. Watt, of Belvue; G. I. Pohek, A. D. Smith, R. G. Hill, W. T. McMahon, A. Morrall and J. M. Jennings, of Wamego.

"Letters from W. F. Richardson, of Havensville; H. S. Roberts, of Manhattan, and J. Vanvliet, of Wheaton, were read stating their inability to be present, but warmly advocating the object for which the meeting was called and promising their support of

the effort.

"The meeting was called to order at 2 o'clock, by Dr. A. D. Smith, of Wamego, temporary president, who stated the object of the meeting. Dr. Smith then suggested that we proceed to effect a permanent organization, and a motion to that end was made, seconded and carried, and Dr. G. C. Beals, of Alma, was nominated for permanent president. No other nomination for president was made and Dr. Beals was unanimously elected.

"Dr. J. M. Jennings, of Wamego, was then nominated and elected as permanent secretary.

"Dr. A. D. Smith, of Wamego, was then chosen as first vice-president, and Dr. W. T. McMahon, of Wamego, as second vice-president.

"Dr. A. H. Brill, of Louisville, was nominated and elected as treasurer.

"The subject of a bill to present to the legislature for their consideration was then freely discussed, and it was the unanimous conclusion that such a law should be enacted that would not only meet the requirements of the times, but the indorsement of all honest physicians and the co-operation of the general public, whose interest we are endeavoring to protect, and a motion was made that the president appoint a committee of three on legislation, whose duty it shall be to recommend a bill and report at the next meeting of this society. The motion was seconded and carried, and Drs. Wilhoit, Pohek and Hill were appointed.

"A motion was then made and seconded that a committee of two be appointed on finance, to act with the treasurer; motion was lost.

"The subject of a name for our society was suggested, and Dr. J. W. Wilhoit proposed as a name, 'Kaw Valley Medical Act Association,' which was by a vote adopted.

"In order to meet the expenses of the society a motion was made, seconded and carried, that a membership fee of fifty cents be charged.

"A motion was made and seconded that a committee of three be appointed to formulate a constitution and by-laws for the government of the society; motion was carried and Drs. Gundry, McMahon and Jennings were appointed as such committee.

"On motion the secretary was instructed to have the proceedings of this meeting printed and to send to all neighboring physicians a copy thereof.

"On motion the meeting adjourned to meet on September 20, 1894."

J. M. JENNINGS, Secretary.

Tri-State Medical Society of Iowa, Illinois and Missouri.

To Editor Kansas Medical Journal.

DEAR SIR—The third annual session of the Tri-State Medical Society will be held at Jacksonville, Ill., October 2d and 3d, 1894. The secretary is authorized to announce that papers will be read by the following gentlemen:

J. H. Kellogg, M.D., Battle Creek, Mich.; Joseph Eastman, M.D., LL.D., Indianapolis, Ind.; A. H. Ohmaun-Dumesnil, A.M., M.D., St. Louis, Mo.; W. B. LaForce, B.S., M.D., Ottumwa, Ia.; Sarah Vasen, M.D., Quincy, Ill.; Charles W. Adams, A.M., M.D., Kansas City, Mo.; E. H. King, M.D., Muscatine, Ia.; Heine Marks, M.D., St. Louis, Mo.; John Punton, M.D., Kansas City, Mo.; Boerne Bettman, M.D., Chicago, Ill.; J. F. Binnie, M.D., C.M., Kansas City, Mo.; Anne H. McFarland, M.D., Jacksonville, Ill.; James H. Etheridge, A.M., M.D., Chicago, Ill.; A. A. Henske, A.M., M.D., St. Louis, Mo.; M. P. Hatfield, M.D., Chicago, Ill.; Ellet Orrin Sisson, M.D., Keokuk, Ia.; B. B. Griffith, M.D., Springfield, Ill., Jacob Block, M.D., Kansas City, Mo.; James A. Close, M.D., M.R.C.S., St. Louis, Mo.; James Moores Ball, M.D., St. Louis, Mo.; W. M. Catto, M.D., Decatur, Ia.; J. Fred Clarke, B.S., M.D., Fairfield, Ia.; Geo. D. Purinton, A.M., M.D., P.H.D., St. Louis, Mo.; S. G. Gant, M.D., Kansas City, Mo.; D. C. Brockman, M.D., Ottumwa, Ia.; Frank Parsons Norbury, M.D., Jacksonville, Ill.; Robert H. Babcock, M.D., Chicago, Ill.

It is expected that Professors Senn and Murphy, of Chicago, will both be present and read important papers. The second day's session will be held in conjunction with the Capital District Medical Society of Illinois.

It is expected that reduced rates will be obtained on all railroads, and no doubt the meeting will be the best yet held in the history of the Tri-State Medical Society.

The address on medicine will be delivered by Dr. N. S. Davis, Jr., of Chicago. The address on surgery will be by Dr. A. V. L. Brokaw, of St. Louis, Mo.

JAMES MOORES BALL, M.D., Sec'y.
810 Olive Street, St. Louis, Mo.

O'Brien Memorial.

The Topeka Academy of Medicine and surgery met in A. O. U. W. parlors at 8 o'clock P.M., Monday, September 10. There were present:

Drs. Grubbs, Coldren, Beers, Lewis, Cannon, Ward, Pelton, McGuire, Munn, Stewart, McCrea, Hamilton, Church, Adams, W. E. McVey, R. E. McVey, McClintock, Barnes, Lindsay, Mitchell. Meeting was called to order by the secretary and Dr. L. Y. Grubbs elected temporary chairman. This being a memorial of Dr. O'Brien all business was dispensed with. The committee on resolutions reported the following, which report was adopted:

RESOLUTIONS OF THE TOPEKA ACADEMY OF MEDICINE AND SURGERY.

WHEREAS, Dr. Michael O'Brien, an esteemed member of the Topeka Academy of Medicine and Surgery, has, in the infinite wisdom of God, been called from the duties of this life. We, his associates, recognize that in his death our country suffers the loss of a patriotic citizen who gave proof of his loyalty by years of service in her defence. The medical profession mourns him as one who was for years a toiler in the ranks, ever striving to elevate the standard of our noble profession; his family, the loss of husband and father, who filled the full measure of devotion in these sacred offices. To these bereaved ones we point to Him who can all our sorrows heal. Therefore, be it

Resolved, by this Society, That we deeply feel his loss; we will miss his manly presence, his kindly courteous manners, his words of wisdom in our councils, and desire to express our sorrow that our loved and honored associate has been taken from us. And that these resolutions be spread upon the records of this Society and published in the daily papers of the city and in the KANSAS MEDICAL JOURNAL, and that an engrossed copy be transmitted to his wife.

DR. L. H. MUNN.
DR. S. G. STEWART.
DR. C. A. MCGUIRE.

Dr. L. H. Munn presented the following medical history:

Mr. President and Fellows of the Academy—Dr. O'Brien's final illness is the story of an asthenic or adynamic dysentery, and can be very briefly told. He had for several weeks been complaining, had not been up to his usual standard all summer. No definite line of symptoms; headache, more than the usual trouble with his digestion. At times a slightly elevated temperature. Thinking that a change might benefit him, he decided upon a trip to Salt Lake City, designing spending a few weeks in the mountains of Colorado. On arriving at Colorado Springs upon his return trip, he was feeling so badly that he only stayed one night and came directly home.

The day of his arrival, Friday, the 17th, his bowels were causing him a little trouble, had some diarrhœa, limited his diet, took three C. C. pills. Saturday suffered much, vomited once or twice, had severe gripings, bowels moved freely. Sunday, had had a fairly good night, slept well, got up and shaved, wanted to dress, but Mrs. O'Brien prevailed upon him to stay in bed.

When I saw him Monday morning for the first time he had passed a miserable night, was suffering greatly; his gastro-intestinal symptoms had increased; he had had so much pain in the night that he had taken two ¼-grain doses of morphia. At the time

of my visit was just getting over a chill, which had lasted twenty or thirty minutes; quite sick at his stomach; was vomiting quite frequently. He attributed his nausea to the morphia taken in the night. Bowels had moved two or three times; temperature was 104, pulse 100, respiration 22. Attributing gastro-intestinal irritation to local trouble and malaria, I prescribed a bismuth and soda mixture, together with full doses of quinia. At noon, there being no improvement in his symptoms, and wishing to flush out his gut more completely, I ordered calomel, gr. ¼ every hour, until the full effect was secured. At 6 P. M. his temperature was 97½. During the remainder of his illness his temperature ranged between 99° and 101°, only going above 101° a few hours before his death, when it reached 105° in the axilla.

Tuesday, the 21st, the tormina, tenesmus and vomiting keeping up, not yielding to any of the ordinary remedies suggested, I began giving him morphia sulph. gr. ¼, hypodermically, under the effects of which he got some rest and retained his milk and stimulants to a limited extent. The dejecta had in the night become glairy, stringy and mixed with blood. I commenced washing out the large intestine with a hot saline solution every four hours, gave him morphia and atropine hypodermically as needed, bismuth subnitrate, gr. 40, every three hours, predigested milk, and alcohol in many forms for support.

Wednesday, the night was a miserable one for him, up and down constantly, stomach rejecting everything, skin cold and clammy, very much exhausted. Gave him morphia sulph. ⅓ gr., atropia sulph. gr. 1-150, hypodermically. Feeling quite discouraged, Dr. S. J. Stewart was called in consultation, and from this time until the end was in constant attendance, dividing with me the responsibility and anxiety of his treatment.

Aside from the fact that each day found him a little weaker and nearer the end, the story of his life for the next four days varies but little. The washing out of his colon causing him so much pain and suffering, apparently doing him little if any good, we stopped it, depending upon the occasional use of a cocaine suppository to relieve the tenesmus; support, stimulants, morphia, atropia, strychnia, as the symptoms warranted.

Sunday noon J. C. McClintock and C. A. McGuire were called; Dr. D. C. Jones came up from Leavenworth Sunday evening; these gentlemen went fully into the history and course of the case, holding out but little hope, advised a continuance of our plan of treatment.

Dr. Jones spent the night with the Doctor, ministering to his wants, and by his presence giving much comfort and encouragement to the patient and family.

Monday morning there seemed some improvement in his condition, stomach not so irritable, discharges from gut firmer and not so frequent; tormina and tenesmus less, did not require quite so much opium to hold him; still, pulse was weaker and dicrotic strychnia nitrate gr. 1-20, hypodermically, would for two or three hours increase its strength and tone.

By evening this had all changed, the glairy, stringy matter, mixed with blood, which had been the type of his discharges for the previous six days, gave way to large watery, fetid, greenish-brown stools; looked like water in which raw flesh had been washed; due likely to a gangrenous condition of the gut, strychnine, morphia and all our other efforts having but little effect.

His pulse became small and feeble, skin pale, a clammy moisture covered it, tongue glazed, constant hiccough, the low muttering delirium, with occasional lucid intervals, gave way to complete coma some hours before his death at 4 P.M.

BIOGRAPHICAL, By Dr. S. G. Stewart.

The subject of this sketch, Dr. Michael O'Brien, was born at Milltown Bay, County Clare, Ireland, on the 6th of August, 1841.

When about seven years of age the family came to the United States and settled at Winstead, Conn., remaining there until he was sixteen years of age. While living at this place he attended the public school. In 1858 the family again concluded to change

their residence and removed to Fort Leavenworth, Kan. On the 11th of July, 1859, he enlisted in the regular army and was appointed artificer and armourer to his command. While in this service he occupied his leisure time in reading and study, his aim being to improve his mind and fit himself for better positions in the service. He soon attracted the attention of his superior officers as a soldier who attended to all his duties with scrupulous care, doing everything, no matter how trivial, in the best possible manner. From this service he was detached to serve as hospital steward in the United States Hospital at St. Louis. He filled this office with credit to himself and benefit to those to whom he ministered. In this position he had good opportunities of pursuing his favorite studies.

So well did he attend to his duties that his fidelity to every trust called forth the commendations of the officers in charge, and he was recommended to the Department at Washington for a commission in the regular army. This he received, assigning him as second lieutenant to Battery F, First Artillery, and bearing date of May 11th, 1864. This important office was ably filled, and when we remember that the young lieutenant, without experience, was placed in command of a veteran battery that had served with distinction through all the hard campaigns of the Army of the Potomac until this time, those of you who have seen service can well appreciate the trying experience he was subjected to, but his previous training, his studious habits, his well-informed mind, enabled him to be master of the situation. He joined his command in May, 1864, at the commencement of that memorable campaign beginning with the battle of the Wilderness and ending at Appomatox, a year into which was crowded more battles, more suffering and greater results than any other recorded in the history of our country. The difficulties and dangers of this campaign brought out the quality of courage that he possessed in such high degree, and was sufficient to mark him a hero. He was commissioned a first lieutenant in the same command, serving until 1869, when he resigned. On leaving the army he again took up the study of medicine, began while a hospital steward. He graduated in medicine from Bellevue Medical College, New York, in 1872, located in New York City, and was appointed a member of the Board of Health. From New York he came to Kansas, and in the month of February, 1872, in the city of Topeka, was united in marriage to Mrs. Mary A. Smith, who, with her daughter, survive him. From Topeka he went to Arizona as a contract surgeon, serving with General George Crook in his campaigns against the Apache Indians; from thence to Camp Supply, Camp McDowell, Fort Dodge, Fort Hayes, Fort Larned and Fort Lyon. He was with General Miles in his winter campaign against the Indians. During this service he was attached to the Sixth Cavalry. In 1882 he was commissioned first lieutenant in the Fourth Artillery, this being the rank held by him when mustered out in 1869. Two years later was retired on account of disability incurred while in the line of duty. After his retirement he selected Topeka as his home, where he resided until his death. The Doctor did not practice medicine after his retirement, but was an interested member of our profession, serving three terms as our president, he engaged in business in the city as secretary of the Water Works Company, and on the retirement of the late Dr. Redden from the position of secretary of the State Board of Health he was appointed secretary, serving about one year. We have thus briefly given the prominent events in the life of Dr. O'Brien; such a life is worthy a more complete record. In reviewing the life of our departed friend we cannot fail to have been impressed with the indomitable energy and courage that characterized him from his boyhood. Everything he did was well done; in every position he excelled; as a subordinate he obeyed, doing all his work in the best possible manner. As an officer of the line he was rated with the best, and in medicine he took no second place. As a medical officer in the army he commanded the respect of his corps, his council was valued

and sought by his professional associates. He honored every position in which he was placed. What a grand record! Those who knew him best, whose privilege it was to have heard him speak concerning his hopes of a future life could not fail to be impressed with the belief that he had that "noble anchor," viz., "A correspondence fixed with heaven." All who witnessed his calm courage in the last hours felt that he was "sustained by an unfaltering trust," and so he breathed out his spirit. While we mourn our departed friend let us rejoice that he has left us the example of a noble life. And may it help us to renew our devotion to all that is good and true.

Each member of the society expressed his love and appreciation of the noble character, courteous manners and intelligence of our deceased brother, who was a soldier, a physician and a gentleman.

On motion of Dr. Ward the society adjourned out of respect to the memory of Dr. O'Brien.

W. E. McVEY, Secretary.

Society Proceedings.

Cases Presented and Topics Discussed—Partial Descent of Right Testicle—Gunshot Wound, Ball Passing Through Stomach, Intestines and Kidney, with Recovery—A Paper on Mono-Therapeutics; Also one on "A Few Suggestions on the After Treatment of Surgery of the Abdomen"—Gonorrhœal Ophthalmia—Case Presented of Congenital Cataracts—Report of a Case of Ectopic Pregnancy with Operation and Recovery.

The Central Branch Medical Society met in Greenleaf in the opera house Thursday, September 6, 1894, Dr. A. E. Andrews in the chair.

Present: Drs. Stapleton and Maintz, of Linn; A. L. Roseborough, of Barnes; D. W. Humpheyville and C. W. Hurley, of Waterville; R. S. Fillmore, Blue Rapids; Jacobs, Green and Andrews, of Washington; Smith, of Hanover; Morton, of Green; Armstrong and Gardner, of Greenleaf; Ward, Sheldon, Wall and Minney, of Topeka.

After the reading of the minutes of the previous meeting and the routine business of the meeting, Dr. Armstrong presented the following clinic: A boy 11 years old, fairly well developed, with partial descent of right testicle. Since the boy had experienced no trouble from it as yet, he had advised letting it alone, but wanted the opinion of the society in the case, and especially the prognosis. The doctor's opinion was confirmed respecting non-interference, and that there would in all probability be no trouble resulting, barring accident.

In the discussion of the paper on mono-pharmacy, while some combinations were indorsed, yet the prevailing sentiment favored simplicity of prescribing as being the safest and most scientific. Dr. Andrews ventured the assertion that it was "lack of knowledge that caused us to make so many combinations of remedies in our therapy."

Dr. Armstrong presented a case of congenital cataract in a boy 7 years old, with strabismus. The grandfather had cataract when 30 years old, and the mother of the boy had amblyopia of one eye. The boy's eyes were not well developed, but since he was completely cataractous and there was perception of light, an operation was advised. In answer to the question "What caused the non-development of the globe of the eye?" it was suggested that the same factor which produced the pathological condition of the lenses prevented the development of the globes.

Dr. Green reported the following case:

Mr. E., age 19, American, received pistol shot injury July 27, about 1:30 A.M., at Lynn, Kas.; range, 12 or 15 feet; weapon, a .32 caliber revolver. The ball entered body, striking the sixth rib about 1½ inches to right of apex beat of heart, glanced downward, its course being downward and backward, passing through diaphragm, injuring the stomach and left kidney, and stopping in region of left kidney. For early history of case I am indebted to Drs. Stapleton and Moore, under whose care he was for a few hours.

Patient did not fall when shot. Walked a distance equal to 1½ squares to Dr. Staple-

ton's office. Vomited blood at about two-thirds the distance, and again on reaching the office of Dr. S. From time of injury until 3 A.M. of the date of injury he vomited five times and each time vomited blood. The quantity of blood vomited was estimated by Drs. S. and M. to be one-half common tin wash basin. At 3 A.M. of date mentioned vomiting ceased and did not recur.

I saw the patient at Lynn at office of Dr. S. about five hours after receipt of injury. Shock very severe. No external bleeding, but symptons indicated internal hemorrhage. No blood had been expectorated, nor has been at any time.

Did not detect any abnormal dullness over left side of chest. Left side of abdomen seemed filled with blood clot, dullness extending over entire left side of abdomen and in umbilical region, extending a little to right of median line.

Wound was slightly protected by absorbent cotton.

Shock increased after my arrival and also symptoms of renewal of hemorrhage. Friday night about 8:30 shock was very severe and heart failure threatening. Digitalis had no appreciable effect; 1-40 gr. strychnia gave necessary support to heart about midnight and patient slept well.

Morphia hypodermatically as needed.

Heart failure threatened again on Saturday evening. Strychnia repeated. No heart trouble occurred from this date.

Patient brought home on C. B. R. R. from Lynn same day of injury, reaching home about noon. Dressing of wound was simple as could be made.

Chest walls and abdominal walls were washed with soap and water and then with bichlor. sol.; wound dusted with iodoform, covered with iodoform gauze and then sublimate gauze, the whole held in place by adhesive strips.

With reaction symptoms of peritonitis began to develop, *i. e.*, pain, tenderness and distension of abdomen and increase of temperature. Tenderness diffuse.

Ice water compresses were now (Saturday) brought into use and continued for about ten days. Compresses covered lower portion of chest and entire abdomen. To this was added for comfort frequent sponging over back and limbs with ice water, which together with a vigorous use of large fans kept the patient fairly comfortable in spite of the intense heat.

Area of dullness in abdomen noticeably less by Saturday evening, and from this time rapidly disappeared. Anodynes were not used after the fourth day.

Nourishment and water by enema until fourth day, when teaspoonful of water was allowed every four hours. The water being well borne, liquid nourishment was begun in one ounce doses during the fifth day and gradually increased until the end of the second week, when a liberal allowance of soup, milk, etc., was allowed.

No attempt was made at any time to probe the wound.

Urine passed soon after the patient reached Dr. S's office; was said to be normal. The urine passed the second time after the injury was very bloody, and bloody urine continued to pass for several days, becoming normal in appearance about the sixth day.

Bowels moved spontaneously, evacuation showing blood during 48 hours.

Dr. Humphreyville reported verbally a similar case, and owing to the smallness of the bullet the patients bowels were splinted with gum and made a good recovery. If the bullet had been large an operation would have been indicated. Dr. Ward suggested that because this case got well it did not militate against operative interference, and this was the exception instead of the rule. He congratulated Dr. Green, as did the whole society, on his masterly noninterference. Dr. Green said he was prepared to operate on a moments notice but the indication was not present.

Dr. Sheldon deprecated the practice of probing gunshot wounds (which was not done in Dr. Green's case) especially of the cavities, and urged that it be stamped with disapproval. Concurred in by the society.

Dr. Ward's paper (see next issue).

Discussion: The paper is in harmony with the best practice. One thing I have not carried out, that is the abstinence from

fluids six to twelve hours before the operation. After the operation for the great thirst and persistent vomiting I permit the patient to take from one-half to one drachm of hot water every half hour. Also for the vomiting small doses of perchloride of mercury and cocaine.

Dr. Ward: The thirst in the main is due to exposure of the peritoneum to the atmosphere, hence the smaller the incision and the quicker the operation the less the thirst and shock and the greater safety to the patient. Hot water, hot milk and hot tea after the operation for the relief of vomiting and the comfort and nourishment of the patient. I do not use chloroform.

Dr. Wall's paper on "Gonorrheal Ophthalmia" (see pp. 477-480) was next discussed.

Dr. Gardner suggested instead of using a probe that wooden toothpicks be substituted and the cotton wrapped around them, and when once used they could be thrown away. This was a preventive measure, as there was no disinfecting required and no danger of communicating the disease to others. The doctor disapproved the method of some of the large hospitals where a dozen bottles were arranged with a camel's-hair brush in each one, and the brush used on patients promiscuously and put back in the bottle.

Dr. Maintz reported a case of "Ectopic Pregnancy," which was operated on by Dr. Sheldon.

Dr. Sheldon made the following report on the operation:

After a full consultation an exploratory laparotomy was determined upon to relieve the intestinal obstruction that existed, and which we believed to be due to adhesive bowels, the result of former peritonitis, and to determine, and if possible relieve, the other obscure pathological conditions that existed.

This was done under the strictest aseptic conditions. The peritoneum was found highly inflamed, and the pelvic and abdominal cavities were found filled with dark blood, much of it coagulated, probably over a gallon in all. This was removed and the ruptured tubal pregnancy was located on the right side and the sac and placenta, together with the diseased ovary and tube, were brought out into the lower angle of the wound and ligated off. The abdominal and pelvic cavities were thoroughly irrigated with sterilized water until thoroughly cleared of all blood and clots. Search was then made for the constricting bowels that were supposed to be the cause of the intestinal obstruction; these were found in several parts of the abdominal cavity and divided, which completely relieved the bowels.

The cavity was again irrigated and closed without drainage, and now, three weeks after the operation, our patient is making a satisfactory and uneventful recovery. The left ovary was not removed, as it was reasonably healthy except several small cysts which were removed. As you will observe by examining these specimens the sac that had contained the fœtus, and which was ruptured, had formed on the lower border of the right ovary with a cavity of of about two ounces capacity. The placenta, which is about three inches in diameter, was located in the fallopian tube below the folds of the broad ligament.

The fœtus was not found and was lost in the mass of clotted blood or had been absorbed by the peritoneum.

I think that one cause of the inaction of the bowels was the anti-peristalsis of the intestines caused by the extreme tympanitic condition that existed.

The chief lessons to be learned by the report and study of this case is, first, the uncertainty of diagnosis in some of these cases of ruptured tubal pregnancy, especially when complicated with intestinal obstruction; second, the wisdom of making or doing an exploratory laparotomy in doubtful cases that do not yield to medical treatment.

I was ably assisted in this operation by Drs. Maintz and Stapleton of Linn, and Dr. Scoville, of Concordia, Kas., and especial credit is due to Dr. Maintz for the subsequent intelligent and faithful management of the case.